LAWRENCE PUBLIC SCHOOL
MEDICATION PARENT PERMISSION/ADMINISTRATION PLAN

NAME OF STUDENT: _____ **DATE OF BIRTH**_____ **ID#**_____ **Classroom** _____

NAME OF LICENSED PRESCRIBER_____ **PRESCRIBERS #Tel:** _____**Fax:** _____

DRUG/FOOD ALLERGIES_____ **DIAGNOSIS:** _____

MEDICATION: _____ **DOSAGE**_____**FREQUENCY:** _____ **ROUTE OF ADMINISTRATION:** _____

SPECIFIC DIRECTIONS/TIMES TO BE GIVEN: _____

SIDE EFFECTS: _____

_____

_____

REQUIRED STORAGE CONDITIONS: **DOUBLE LOCKED MEDICINE CABINET**

PLAN FOR FIELD TRIPS: _____**Can self-administer (Epipen and inhalers only) YES** _____ **NO** _____

OTHER PERSONS TO BE NOTIFIED OF MEDICATION (WITH PARENT PERMISSION) _____

OTHER MEDICATIONS BEING TAKEN BY STUDENT IF NOT IN VIOLATION OF CONFIDENTIALITY _____

LOCATION WHERE MEDICATION ADMINISTRATION WILL OCCUR: HEALTH ROOM _____ **OTHER** _____

PLAN FOR MONITORING MEDICATION IF NEEDED: _____

I HEREBY REQUEST THE SCHOOL NURSE OR OTHER DESIGNATED PERSON GIVE THE ABOVE MEDICATION TO MY CHILD DURING SCHOOL HOURS.

PARENT/GUARDIAN NAME_____ **CELL NUMBER** _____

ADDRESS_____ **TELEPHONE NUMBER** _____/_____
HOME **WORK**

EMERGENCY CONTACT _____ **CONTACT NUMBER**_____ **RELATION** _____

SCHOOL NURSE SIGNATURE _____ **PARENT SIGNATURE**_____

DATE_____ **DATE**_____